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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a health resurvey and investigation of complaint # 56259<br><br>A revised copy of the deficiencies was sent to the facility on 5/4/12. | F 000 | | |
| F 205 SS=D | 483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR<br><br>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.<br><br>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 59 residents. The sample included 15 residents. Based upon record review and interviews the facility failed to provide a bed hold policy to 1 (#32) of 1 sampled resident and family member after the resident | F 205 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 205 | Continued From page 1 | F 205 | | |

was admitted to the hospital.

Findings included:

- Review of resident #32's April 2012 Physician Order Sheet identified the resident had diagnoses that included: disorganized schizophrenia, bacterial pneumonia, dyspepsia, cellulitis and abcess of the upper and forearm, constipation, rash, disturbance of salivary secretion, esophageal reflux, irritable bowel syndrome, hemorrhage of the rectum and anus, gastritis and gastroduodenitis with hemorrhage, extrapyramidal and abnormal movement disorder, allergic rhinitis, and hypercholesterolemia.

A nurse's noted dated 2/16/12 timed 11:41 P.M. documented the resident fell at 10:15 P.M. near the nursing station, staff observed the resident falling straight backwards with not enough time to prevent the fall, and staff observed the resident's left leg was rotated outwards and shorter than his/her right leg. The note included the resident voiced pain during range of motion to his/her left leg and voiced pain to the right side of his/her head, the resident had increase confusion, and the facility received a physician's order to transport the resident to a local hospital emergency room for evaluation and treatment.

A nurse's note dated 2/17/12 timed 3:34 A.M. documented the resident was admitted to the local hospital.

Review of the resident's clinical record lacked evidence the facility provided a bed hold at the time of transfer. The clinical record further lacked

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| F 205 | Continued From page 2<br>evidence the facility provided a bed hold notice to the resident and/or a family member after the resident was admitted to the hospital.<br><br>Review of the resident's Minimum Data Set 3.0 entry record with an assessment reference date of 3/1/12 recorded the resident returned to the facility on 3/1/12.<br><br>During interview with Administrative Staff A on 5/1/12 at 5:15 P.M. the staff stated the facility did not provide a copy of the bed hold to the resident at the time of the transfer because the facility was not aware the hospital was going to admit the resident. Administrative Staff A stated the facility did not provide a bed hold notice to the resident and/or a family member after the resident was admitted to the hospital.<br><br>The facility's transfer, discharge, therapeutic leave, room change and/or Bedhold Policy dated 8/96 included emergency transfers will be in writing to the resident and family members or legal guardian within twenty-hours of transfer and included the transfer/bedhold policy.<br><br>The facility failed to provide this resident and family member a copy of the bedhold policy after the resident was admitted to the hospital. | F 205 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable | F 279 | | |

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| F 279 | Continued From page 3 | F 279 | | |

objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 15 residents. Based upon record observation, record review, and interviews the facility failed to develop a coordinated plan of care that identified the care and services for 1 (#4) of 1 residents identified for Hospice Services.

Findings included:

- Review of resident #4's Physician Order Sheet dated 4/11/12 identified the resident had diagnoses that included: psychosis, history of urinary tract infection, generalized pain, splenomegaly, pancytopenia, anxiety, hypertoncity of bladder, dementia with lewy bodies, esophageal reflux, malignant neoplasm of the large intestine and rectum, epilepsy, depressive disorder, peripheral vascular disease, hypertension , abdominal pain, lack of

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| F 279 | Continued From page 4 | F 279 | | |

coordination, edema, nutritional deficiency, personality disorder, hypothyroidism, and intestinal malabsoprtion.

The resident's significant change Minimum Data Set (MDS) 3.0 with an assessment reference date (ARD) of 3/29/12 identified the resident had short and long term memory problems, displayed behaviors, did not walk in the room or corridor, required extensive staff assistance with all other activities of daily living, utilized a wheelchair, and did not have a condition or chronic disease that might result in a life expectancy of less than 6 months.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 4/12/12 documented the resident currently received Hospice Services.

The resident's care plan dated 4/19/12 included the resident received Hospice Services related to end of life care, the facility notified Hospice of any change in the resident's condition or medication changes, and coordinated the resident's care plan with Hospice. The resident's care plan did not include the frequency or services Hospice provided nor did it include what medications, supplies or durable medical equipment Hospice provided for the resident.

A doctors order dated 3/28/12 (time unknown) read for the resident to receive Hospice Services due to a diagnosis of dementia with a life expectancy of less than 6 months.

On 4/26/12 at 7:30 A.M. the resident sat in a Broda chair at the dining room table.

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| F 279 | Continued From page 5<br><br>On 4/30/12 at 2:15 P.M. the resident was in bed. Observation at that time revealed the resident utilized a low air loss bed, and had a scoop type mattress in place.<br><br>During interview with direct care staff J on 4/30/12 at 4:37 P.M. the staff stated the resident received Hospice services but did not know what the services, equipment, or supplies Hospice provided for the resident.<br><br>During interview with licensed nurse I on 5/1/12 at approximately 2:00 P.M. the staff confirmed the resident received Hospice Services and the residents MDS with an ARD of 3/29/12 did not include the resident had a life expectancy of less than 6 months. The staff confirmed the physician's order was dated 3/28/12. The staff confirmed the resident's care plan did not identify the care and services the hospice provided.<br><br>During interview with Administrative Staff A on 5/1/12 at approximately 2:30 P.M. the staff confirmed the resident's care plan did not identify the care and services the hospice provided.<br><br>The facility's Delivery of Service Terminal Illness, Death, and Dying Policy and Procedure revised October 2009 included all services provided would be documented in the social service section of the medical record, and the care plan would be coordinated with hospice.<br><br>The facility failed to develop a coordinated care plan that identified the care and services which the hospice and nursing facility would provide. | F 279 | | |
| F 309 | 483.25 PROVIDE CARE/SERVICES FOR | F 309 | | |

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| F 309 SS=D | Continued From page 6 HIGHEST WELL BEING | F 309 | | |

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 15 residents. Based upon observation, record review and interview the facility failed to ensure that 1 (#10) of 1 residents was properly positioned during meals.

Findings included:

- Review of resident #10's Physician Order Sheet dated 4/11/12 identified the resident had diagnoses that included: Schizoaffective disorder, cataract, hypertension, constipation, rash, edema, insomnia, dementia with lewy bodies, esophagus disorder, neurogenic bladder, bipolar type I, anxiety, hypopotassemia, flaccid hemiplegia affecting dominant side, psychosis, borderline personality disorder, depressive disorder, infantile cerebral palsy, abdominal lymph nodes, and cerebral vascular accident (CVA).

The resident's annual Minimum Data Set 3.0 with an assessment reference date (ARD) of 10/31/12 identified the resident scored a 14 (cognition intact) on the Brief Interview for Mental

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Status, required extensive staff assistance with bed mobility, transfers, locomotion on and off of the unit, dressing, toilet use, hygiene, did not walk in the room or corridor, required limited staff assistance with eating, utilized a wheelchair, and did not have swallowing difficulties.

The resident Activities of Daily Living (ADLs) care area assessment dated 11/14/12 documented the resident had a long term history of physical impairment related to a CVA, and cerebral palsy, required extensive staff assistance with ADL's, required staff assistance with positioning while in the bed and chair, staff encouraged the resident to propel the wheelchair by himself/herself to promote independence, and did not have swallowing difficulties.

The resident's quarterly MDS 3.0 with an ARD of 4/2/12 identified the resident scored a 11 (moderately impaired cognition) on the BIMS, did not exhibit any behaviors, required limited staff assistance with eating, and required extensive staff assistance with all other ADLs.

The resident's care plan last reviewed 4/19/12 included the staff set up the resident's meals, provided proper positioning prior to the meal. An entry dated 4/18/12 documented the facility received a referral for physical, occupational and speech therapy for evaluation and treatment for eating, swallowing, seating, positioning and choking. The care plan included (entry dated 12/30/11) the resident's seating/positioning when in the wheelchair included the resident was to be tilted in space at the highest position for meals to optimize his/her position during meals, and tilt in space at lower level for comfort and function

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| F 309 | Continued From page 8 | F 309 | | |

during mobility to optimize posture for wheelchair mobility.

A physician's order dated 4/18/12 (time unknown) included for physical therapy, occupational therapy, and speech therapy to conduct an evaluation and treat as indicated relating to the resident's positioning in the wheelchair and swallowing.

A nurse's noted 4/18/12 timed 12:42 P.M. documented the resident sat in the Broda chair slumped over to the left side, staff repositioned the resident, the resident returned to the slumped position, and staff reported the resident had coughing episodes while eating meals.

A nurse's note dated 4/20/12 timed 1:43 P.M. documented the resident continued to use the tilt in space at highest position to optimize his/her posture at meals.

A physical therapy (PT) plan of care dated 4/25/12 documented the resident was referred to PT for positioning deficits due to congenital cerebral palsy with right spastic hemiplegia, had been recently repositioned in a Broda peddler, the facility staff noticed the resident had positioning difficulties in the past month which had resulted in leaning more, and also had some swallowing difficulties as he/she cannot maintain an upright position in the wheelchair during meals.

A speech therapy plan of care dated 4/25/12 documented the resident was referred to the speech language pathologist due to nursing complaints of the resident patient coughing and choking during meals for the last 4 days. The

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| F 309 | Continued From page 9 | F 309 | | |

plan of care included the resident had swallowing difficulties caused by cerebral palsy, the resident's eating habits and poor positioning during meals which placed the resident at risk for aspiration.

On 4/30/12 at 7:50 A.M. the resident sat in the Broda chair at the dining room table in a slumped position. At this time staff delivered the resident's breakfast meal which consisted of eggs, muffin, and a bowl of cold cereal cereal. At 8:02 A.M. (after the resident was eating the meal) direct care staff J placed the Broda chair in the upright position and the resident did not slump as much. Observation at that time revealed a handwritten sign on the back of the resident's Broda chair that read "Please recline me when I am not dining." At 8:03 A.M. the resident ate his/her meal and started to cough.

On 5/1/12 at 7:50 A.M. the resident sat in the Broda chair at the dining room table eating the breakfast meal, and the Broda chair in a reclined position. At that time the resident stated it was hard for him/her to reach his/her food. Direct care staff J at that time stated the Broda chair was not in the upright position, and direct care staff J placed the chair in the upright position. The resident then stated (after the staff placed the chair in the upright position) he/she could reach the food, smiled and said thank you.

On 5/1/12 at 12:18 P.M. the resident sat at the dining room table in the Broda chair. At that time the resident stated he/she needed to be up more in the chair. At that time direct care staff J stated the chair was not in raised in the highest position, direct care staff J raised the chair, and the

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resident stated it was much better.

During interview with the resident on 4/30/12 at 9:40 A.M. the resident stated his/her positioning was uncomfortable during meals, and that he/she would like to sit up higher during meals. The resident also stated at times he/she had coughing episodes during meals.

During interview with nursing administrative nursing staff C on 4/30/12 at 3:19 P.M. the staff stated the facility had concerns about the resident's posturing and swallowing difficulties during meals, and the Broda chair was to be in the highest position during meals.

During interview with direct care staff J on 4/30/12 at 4:34 P.M. the staff stated the Broda chair should not be in a reclining position when the resident ate his/her meals.

During interview with therapy consultant M on 5/1/12 at 10:09 AM the consultant stated the Broda chair should be in the highest upright position when the resident ate his/her meals.

During interview with licensed nurse G on 5/1/12 at 1:20 P.M. the staff stated the Broda chair should be in the highest upright position when the resident ate his/her meals. Licensed staff stated the resident had experienced some swallowing difficulties and coughing episodes during meals.

The facility's policy and procedure for positioning (date unknown) included the purpose of the policy was to promote proper body alignment.

The facility failed to ensure this resident that

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| F 309 | Continued From page 11<br>required extensive staff assistance with positioning at meals and at risk for aspiration was positioned in the Broda chair appropriately. | F 309 | | |
| F 329 SS=E | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 59 residents. The sample included 15 residents. Based on observation, record review and staff interview, the facility failed to identify and monitor targeted | F 329 | | |

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behaviors of psychotropic medications for seven of the ten residents reviewed for unnecessary medications (#31, #46, #43, #25, #20, #27, #19).

Findings included:

- Resident #19 had diagnosis that included paranoid schizophrenia, plantar wart, epilepsy and recurrent seizures, constipation, essential tremor, anxiety disorder, dementia with Lewy bodies, nutritional deficiency, insomnia, sleep disturbance, depressive disorder, hypothyroidism, disturbance of skin sensation, secondary Parkinson's, bipolar disorder, dementia with behavioral disturbance, gastroparesis, Barrett's esophagus, peripheral angiopathy, cardiomegaly, anemia, obsessive compulsive disorder, diabetes mellitus type I, and cataract as listed on the April Physician's Order Sheet (POS) dated 4/11/12. The POS also included the following medications: Lunesta 1 milligram (mg.), a sedative/hypnotic, Cymbalta 60 mg., an anti-depressant, Risperdal 0.25 mg., an anti-psychotic, Geodon 60 mg., an anti-psychotic, and Klonopin 0.5 mg., an anti-anxiety.

The quarterly Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/28/12 recorded a Brief Interview for Mental Status (BIMS) of 9 and the resident received anti-anxiety, anti-psychotic, and anti-depressant medications.

The Care Area Assessment (CAA) dated 12/14/11 for psychotropic medication usage documented he/she had a long term history of mental illness with the use of psychotropic medications. The pharmacist completed a

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medication regimen review on a monthly basis with no new recommendations noted. The Advanced Registered Nurse Practitioner (ARNP) noted he/she was not a current candidate for dose reduction.

The care plan dated 12/29/11 and last reviewed 3/20/12 recorded a potential for drug related cognitive or behavioral impairment due to psychotropic medication usage. The interventions listed nursing staff monitored fluid intake and noted any decreased intake to the charge nurse, nursing staff reported behavioral changes or changes in sleeping pattern to the charge nurse, nursing staff reported changes in Activities of Daily Living (ADL) function to the charge nurse, the pharmacist reviewed medication regimen on a monthly basis, and he/she was offered hard sugar candy for dry mouth.

The Behavior Monthly Flow Sheet for April 2012 listed the following behaviors: agitated, angry, anxiety, continuous yelling, hallucinations/paranoia/delusion, skipping meals, and refusing care. This sheet listed the following medications: Lunesta 1 milligram (mg.), Cymbalta 60 mg., Risperdal 0.25 mg., Geodon 60 mg., and Klonopin 0.5 mg. This sheet did not specify which medications were related to which behaviors.

An observation on 5/1/12 at 8:00 A.M. revealed resident consumed breakfast at dining room table, stood up from the table, picked napkin off the floor, then ambulated towards his/her room.

An interview on 5/1/12 at 11:45 A.M. licensed nursing staff F indicated that the diagnoses were listed beside the prescribed medications and the

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targeted behaviors corresponded to the appropriate diagnoses.

An interview on 5/1/12 at 1:15 P.M. with administrative nursing staff C was unable to provide information on residents' targeted behaviors related to diagnosis and medications.

Review of the facility policy/procedure for Behavior Management Guideline revised January 2011, recorded "prior to the initiation of antipsychotic medication a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use."

The facility failed to identify and monitor for efficacy and side effects of the psychotropic medications.

- Resident #31 had diagnosis that included paranoid schizophrenia, hyperlipidemia, insomnia due to mental disorder, allergic rhinitis, depressive disorder, esophageal reflux, traumatic amputation of arm and hand unilateral below elbow, anxiety, constipation, blindness of both eyes, and agoraphobia with panic disorder as listed on the April 2012 Physician's Order Sheet (POS). The POS included the following medications: Trazodone 250 milligrams (mg.), an anti-depressant, Clozaril 250 mg., an anti-psychotic, Celexa 20 mg., an anti-depressant, and Klonopin 1 mg., an anti-anxiety.

The quarterly Minimum Data Set (MDS)3.0 with an Assessment Reference Date (ARD) of 1/27/12 recorded a Brief Interview of Mental Status

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(BIMS) of 15 and the resident received anti-psychotic, anti-anxiety, and anti-depressant medications.

The Care Area Assessment (CAA) dated 8/25/11 triggered for psychotropic drug use.

The care plan dated 9/30/11 and last reviewed 2/16/12 listed psychotropic medication monitoring for side effects and targeted behaviors included: Trazadone, Clozaril, Celexa, and Klonopin.

The Behavior Monthly Flow Sheet for April 2012 listed the following behaviors: anxiety, continuous yelling, and hyperventilating. The sheet listed the following medications: Trazadone 250 mg., Clozaril 250 mg., Celexa 20 mg., and Klonopin 1 mg. This sheet did not specify which medications were related to which behaviors.

An observation on 4/30/12 at 10:20 A.M. the resident was observed near the entrance door entering from the smoking area, resident was holding cane and requested staff to assist him/her to room, staff escorted the resident to his/her room, resident did not use walking cane during ambulation.

An interview on 5/1/12 at 11:45 A.M. licensed nursing staff F indicated that the diagnoses were listed beside the prescribed medications and the targeted behaviors corresponded to the appropriate diagnoses.

An interview on 5/1/12 at 1:15 P.M. with administrative nursing staff C was unable to provide information on residents' targeted behaviors related to diagnosis and medications.

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Review of the facility policy/procedure for Behavior Management Guideline revised January 2011, recorded "prior to the initiation of antipsychotic medication a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use."

The facility failed to identify and monitor for efficacy and side effects of the psychotropic medications.

- Resident #43 had diagnosis that included schizoaffective disorder, skin and subcutaneous tissue infections, allergic rhinitis, hypertension, post-traumatic stress disorder, borderline personality disorder, esophageal reflux, diabetes mellitus type II, urinary incontinence, rosacea, varicose veins of lower extremities, polycystic ovaries, obesity, hirsutism, coronary atherosclerosis, tobacco use, hyperlipididemia, myalgia and myositis, osteoartherosis, anemia, fibroadenosis of breast, sensoneural hearing loss, lumbago, external thrombosed hemorrhoids, symptomatic menopausal/female climacteric states, psychosis, reactive confusion, pain in joints of pelvic region and thigh, bursitis, osteoporosis, constipation, hypothyroididism, migraine, extrapyramidal movement disorder, hypertension, and insomnia as listed on the April Physician's Order Sheet (POS) dated 4/20/12. The POS included the following medications: Zyprexa 10 milligrams (mg.), an anti-psychotic, Ativan 1 mg., an anti-anxiety, and Paxil 10 mg., an anti-depressant.

The quarterly Minimum Data Assessment (MDS)

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3.0 with an Assessment Reference Date (ARD) of 2/17/12 recorded a Brief Interview of Mental Status (BIMS) of 15 and the resident received anti-psychotic and anti-depressant medications.

The Care Area Assessment (CAA) dated 12/6/11 triggered for psychotropic medication usage.

The care plan dated 9/30/11 and last reviewed 2/16/12 listed psychotropic medication monitoring for side effects and targeted behaviors included: Ativan, Paxil and Zyprexa.

The Behavior Monthly Flow Sheet for April 2012 listed the following behaviors: anxiety, continuous screaming/yelling, hallucinations/paranoia/delusions, isolation, hoarding, damaging property, and giving away items and then accusing others of stealing. This sheet listed the following medications: Zyprexa 10 mg., Ativan 1 mg., and Paxil 10 mg.

An observation on 4/30/12 at 12:30 P.M. revealed the resident sat at the dining room table in a straight back chair.

An interview on 5/1/12 at 11:45 A.M. with licensed nursing staff F indicated that the diagnoses were listed beside the prescribed medications and the targeted behaviors corresponded to the appropriate diagnoses.

An interview on 5/1/12 at 1:15 P.M. administrative nursing staff C was unable to provide information on residents' targeted behaviors related to diagnosis and medications.

Review of the facility policy/procedure for

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Behavior Management Guideline revised January 2011, recorded "prior to the initiation of antipsychotic medication a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use."

The facility failed to identify and monitor for efficacy and side effects of the psychotropic medications.

- Resident #46 had diagnosis that included schizophrenia, edema, hypothyroidism, depressive disorder, hyperlipidemia, adjustment disorder with anxiety, psychosis, mood disorder, personal history of traumatic brain injury, diabetes mellitus type II, and atopic dermatitis as listed on the April Physician's Order Sheet (POS) dated 4/25/12. The POS included the following medications: Paxil 20 milligrams (mg.), an anti-depressant, Haloperidol 5 mg., an anti-psychotic, Seroquel 300 mg., an anti-psychotic, Lorazepam 2 mg., an anti-anxiety, and Hydroxyzine 25 mg., an anti-anxiety.

The significant change Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/7/12 recorded a Brief Interview for Mental Status (BIMS) of 6 and the resident received anti-psychotic, anti-anxiety, and anti-depressant.

The Care Area Assessment (CAA) dated 2/7/12 triggered for psychotropic drug usage.

The care plan dated 12/26/11 recorded potential for drug related complications associated with use of psychotropic medications related to anti-anxiety, anti-depressant, and anti-psychotic

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medications.

The Behavior Monthly Flow Sheet for April 2012, listed the following behaviors: agitated, compulsive, false beliefs, striking out/hitting, intrusive, inappropriate physical/sexual behavior, and trespassing. This sheet listed the following medications: Paxil 20 milligrams (mg.), Haloperidol 5 mg., Seroquel 300 mg., Lorazepam 2 mg., and Hydroxyzine 25 mg. This sheet did not specify which medications were related to which behaviors.

An observation on 4/30/12 at 12:10 P.M. resident seated in wheelchair at dining room table eating lunch.

An interview on 5/1/12 at 11:45 A.M. licensed nursing staff F indicated that the diagnoses were listed beside the prescribed medications and the targeted behaviors corresponded to the appropriate diagnoses.

An interview on 5/1/12 at 1:15 P.M. with administrative nursing staff C was unable to provide information on residents' targeted behaviors related to diagnosis and medications.

Review of the facility policy/procedure for Behavior Management Guideline revised January 2011, recorded "prior to the initiation of antipsychotic medication a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use."

The facility failed to identify and monitor for efficacy and side effects of the psychotropic medications

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- Review of resident #25's 4/25/12 Physician Order Sheet dated 4/25/12 identified the resident had diagnoses that included: Schizophrenia, extrapyramidal abnormal movement disorder, hypothyroidism, rash, hypopatassemia, edema, anxiety, lipoid metabolism, paranoid personality disorder, peripheral vascular disease, esophageal reflux disease, obesity, depression, osteoarthrosis involving multiple sites, hypertension, and convulsions.

The resident's annual Minimum Data Set 3.0 with an assessment reference date of 12/29/11 identified the resident had short and long term memory problems, hallucinations, delusions, and did not receive antipsychotics, antianxiety medication or antidepressants.

The resident's care plan dated 4/23/12 included the resident received the following medications Zyprexa (an antipsychotics), Haldol (an antipsychotics), Ativan (an anti-anxiety), and Klonpin (an anti-anxiety). The care plan included the facility monitored the resident for side effects related to his/her medications and also monitored the resident's behavior.

The resident's March and April 2012 behavior monthly flow sheet identified the facility monitored the resident for the following behaviors: Agitation, continuous pacing, hallucinations/paranoia/delusions, demanding tea, refusing medications, refusing hygiene and showers, and continuous physical aggression and

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failed to show the relationship of drug class/names against specific targeted behaviors.

The resident's behavior monthly flow sheets for April and March 2012 listed the following medications: Haloperidol, Ativan, and Klonopin.

An interview on 5/01/12 at 11:45 A.M. with licensed nurse F about behavior sheets, the staff indicated that the facility listed the diagnoses beside the prescribed medications. The staff could not correlate the resident's targeted behaviors to the medications.

An interview on 5/01/12 at 4:00 P.M., with the licensed staff H regarding targeted behaviors, and medications, the nurse could not relate the correlation of the targeted behaviors to the appropriate medications.

An interview on 5/01/12 at 1:15 P.M. administrative nurse C about targeted behaviors, monitoring, and medications, the staff failed to provide information on resident targeted behaviors related to the medications. This staff failed to provide monitoring of targeted behaviors related to the medications.

The facility policy dated January 2011 indicated, " Prior to the initiation of an antipsychotics medication a physician ' s order is obtained to include the diagnoses and targeted behavior that warrant the medication use. "

The clinical record lacked evidence the facility monitored the effectiveness of the medications.

- Review of resident #27's Physician Order Sheet

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dated 4/11/12 identified the resident had diagnoses that included: paranoid schizophrenia, edema, anxiety, iron deficiency, anemia, constipation, nutritional deficiency, diabetes type 1, allergic rhinitis, asthma, dementia with lewy bodies, neurogenic bladder, depressive disorder, embolism and thrombosis of artery, hypothyroidism, and hyperlipidemia.

The resident's Significant Change Minimum Data Set 7/11/11 identified the resident scored 10 (moderately cognitively impaired) on the Brief Interview for Mental Status, had hallucinations, delusions, and received antipsychotics and antidepressant medications.

The resident's care plan dated 3/22/12 included the resident received Celexa (an antidepressant), Klonopin (an anti-anxiety), Clozaril (an antipsychotic), Geodon (an antipsychotic), Abilify (an antipsychotic) and Seroquel (an antipsychotic). The care plan included the facility monitored the resident for side effects related to the medications and also monitored the resident's behavior.

The resident's March and April 2012 behavior monthly flow sheet identified the facility monitored the resident for the following behaviors: Agitation, crying, yelling, hallucinations/paranoia/delusion and intrusiveness. The behavior monthly flow sheets failed to show the relationship of drug class/names against specific targeted behaviors.

The March and April 2012 behavior monthly flow sheet listed the resident received the following medications: Ability, Geodon, Celexa, Seroquel, Clozaril and Klonopin.

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| F 329 | Continued From page 23<br><br>An interview on 5/01/12 at 11:45 A.M. with licensed nurse F about behavior sheets, the staff indicated that the facility listed the diagnoses beside the prescribed medications. The staff could not correlate the resident's targeted behaviors to the medications.<br><br>An interview on 5/01/12 at 4:00 P.M. the licensed staff H regarding targeted behaviors, and medications revealed the nurse could not relate the correlation of the targeted behaviors to the appropriate medications.<br><br>An interview on 5/01/12 at 1:15 P.M. with the administrative nurse C about targeted behaviors, monitoring, and medications, the staff failed to provide information on resident targeted behaviors related to the medications. The staff failed to provide monitoring of targeted behaviors related to the medications.<br><br>The facility policy dated January 2011 indicated, " Prior to the initiation of an antipsychotics medication a physician's order is obtained to include the diagnoses and targeted behavior that warrant the medication use."<br><br>The clinical record lacked evidence the facility monitored the effectiveness of the medications.<br><br>- Resident #20 diagnoses included: Schizoaffective disorder chronic, hypertension, onychia and paronychia of toe, anxiety disorder conditions classified elsewhere, generalized pain, insomnia due to mental disorder, unspecified, | F 329 | | |

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extrapyramidal diagnoses and abnormal movement disorder, unspecified constipation, and unspecified hypothyroidism.

The annual MDS dated 04/11/12 recorded the resident had a brief interview for mental status score of 15 (cognitively intact), schizoaffective disorder with delusions and hallucinations, anxiety with insomnia, had a mood score of 0, had setup assistance with bathing and supervision at meals, preferences for routine and activities was very important, and received an antipsychotic, antianxiety, and hypnotic medication.

The care area assessment (CAA) dated 4/11/12 for psychotropic medications recorded the resident received Seroquel and Invega for schizoaffective disorder, the antianxiety medication Lorazepam when necessary, and the hypnotic medication Ambien for insomnia. The CAA showed the resident had delusional thinking with paranoia of others, especially where his/her belongings were concerned and became anxious thinking others stole her property. The resident used these medication due to long term history of mental illness with the use of high risk medications.

The care plan dated 4/11/12 reported the potential for drug related complications associated with the use of psychotropic medications and for the staff to monitor for side effects and report to the doctor any antidepressant sedation, and decreased self-esteem. Interventions included for the staff to assess for pain, monitor for side effects and report to doctor any antipsychotic medication side

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effects such as sedation, drowsiness, dry mouth, constipation, blurred vision, extra pyramidal syndrome (EPS), weight gain, and edema,

The care plan dated 4/26/12 for potential for drug related complications associated with use of psychotropic medications related to: antianxiety and antipsychotic medications (Ativan, Lorazepam, Seroquel, Invega). The resident had a diagnoses of EPS and was at risk for constipation, and for the staff to monitor if the resident had a bowel movement at least every 3 days, and to be free of psychotropic related complications.

Review of February 2012, March 2012, and April 2012 behavior sheets reflected that in February 2012 the resident had 6 of 28 days of pacing/restless behaviors, in March 2012 the resident had 11 of 30 days of pacing/restless continuous behaviors, in April 2012 the resident had 18 of 30 days of pacing, restless behaviors between shifts. The behavior monitoring forms listed behavior codes for " continuous pacing, restlessness and elopement risk, " and failed to show the relationship of drug class/names against specific targeted behaviors. The behavior sheets listed Seroquel 400 milligrams (mg), Invega 3mg, and Invega Sustenna intramuscular 156 mg for schizoaffective disorder, Lorazepam 2mg for anxiety, and Ambien 15 mg for insomnia.

An observation on 5/01/12 at 8:10 A.M. licensed nursing staff F identified the resident, and administered the resident the 8:00 A.M. medications.

An observation 5/01/12 at 4:45 P.M., licensed

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| F 329 | Continued From page 26<br>nurse G gave the resident his/her 5:00 P.M. medications which consisted of Seroquel and Propranolol.<br><br>An interview on 5/01/12 at 11:45 A.M. with licensed nurse F about behavior sheets, the staff indicated that the facility listed the diagnoses beside the prescribed medications. The staff could not correlate the resident ' s targeted behaviors to the medications.<br><br>An interview on 5/01/12 at 4:00 P.M., with the licensed staff H regarding targeted behaviors, and medications revealed the nurse could not relate the correlation of the targeted behaviors to the appropriate medications.<br><br>An interview on 5/01/12 at 1:15 P.M. with the administrative nurse C about targeted behaviors, monitoring, and medications, the staff failed to provide information on resident targeted behaviors related to the medications. The staff failed to provide monitoring of targeted behaviors related to the medications.<br><br>The facility policy dated January 2011 indicated, " Prior to the initiation of an antipsychotic medication a physician ' s order is obtained to include the diagnoses and targeted behavior that warrant the medication use. "<br><br>The facility failed to identify which behaviors related to which psychotropic medications on the behavior monitoring sheet for the monitoring of efficacy. | F 329 | | |
| F 412 SS=D | 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS | F 412 | | |

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The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 15 residents. Based upon record review and interviews the facility failed to timely provide dental services to 1 (#18) of 4 residents sampled for dental concerns.

Findings included:

- Review of resident #18's 4/2012 Physician Order Sheet (POS) identified the resident had diagnoses that included: Schizoaffective disorder, hypothyroidism, essential tremors, depressive disorder, constipation, insomnia, rhinitis, and esophageal reflux disease.

The resident's annual Minimum Data Set (MDS) 3.0 with an assessment reference date of 4/6/12 identified the resident scored a 15 (intact cognition) on the Brief Interview for Mental Status, independent will all activities of daily living, and without swallowing difficulties. The MDS included the resident had obvious or likely cavity or broken natural teeth, had mouth or facial pain, and had discomfort or difficulty with

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chewing.

The resident's dental care area assessment dated 4/20/12 documented the resident recently voiced complaints of oral pain and discomfort, was seen by the dentist on 4/3/12 with recommendations for the resident to be referred have all of his/her upper teeth extracted. The CAA included the resident stated he/she wanted dentures following the extractions.

The resident's care plan last reviewed on 4/11/12 included the resident had potential for oral problems related to having his/her own teeth, staff encouraged the resident to practice daily oral care, staff performed regular oral assessments on the resident's mouth, and the facility referred the resident to an onsite dental service in an emergency or for necessary services. The care plan included an entry dated 4/3/12 that included the resident voiced complaints of oral discomfort, was seen by the dentist today, needed a referral for tooth extraction, and the facility would find an oral surgeon that would accept the resident's insurance. An entry dated 4/24/12 included the facility found an oral surgeon that would accept his/her insurance, paperwork was in process and the resident's guardian needed to give consent for services.

A nurse's note dated 3/15/12 timed 5:01 P.M. documented the resident complained of dental pain, stated he/she had an infected tooth, and requested staff to notify his/her primary care physician. The note included staff checked the resident's mouth and did not observe any redness or swelling.

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A nurse's note dated 3/15/12 timed 10:15 P.M. documented the facility contacted the resident's physician, informed the physician the Tylenol did not relieve the tooth pain, and the physician gave an order for 50 milligrams (mg) of Tramadol (pain medication) as needed.

A nurse's note dated 4/3/12 timed 9:56 P.M. documented the resident saw the dentist today at the facility, the resident was concerned that nothing was done except the dentist cleaned his/her teeth, the resident continued to complain about his/her gums hurting and the facility would continue to observe.

A nurse's note dated 4/4/12 timed 2:52 P.M. documented a recommendation for a referral to an oral surgeon was made for extractions, the facility would initiate a search for an oral surgeon that is a medicaid provider in Kansas.

A dental progress note dated 4/3/12 documented the resident presented for prophylaxis, had very poor oral hygiene, the resident reported brushing his/her teeth 1 time per day, the resident needed to brush his/her teeth at least twice a day, the resident needed referred out to have all of his/her upper teeth extracted. The note included the resident's upper teeth were decayed and infected, and the resident would like an upper denture. The note included impressions were started for the upper denture and the resident's teeth needed extracted by an oral surgeon.

A psychosocial progress note dated 4/12/12 (time unknown) documented the resident had his/her own teeth, was independent in his/her oral care

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with some cueing from staff as needed.

A mental health dental note dated 4/24/12 timed 8:01 A.M. documented the resident was to have a tooth pull, was treated for a couple of weeks for dental pain per nursing, refused yesterday to have it pulled and said it is his/her gum that hurts, the director of nursing services met with the resident and explained how a tooth could cause gum pain and illustrated how the tooth was positioned in the gum, and the resident then stated it was okay to set up an evaluation with the oral surgeon. The note included the directory of mental health services would set the evaluation up today as the oral surgeon had not been in since the middle of last week.

The clinical record did not support the facility had spoken to the resident regarding the extractions prior to 4/24/12. The clinical record also lacked evidence the facility had attempted to set up the evaluation with the oral surgeon prior to 4/24/12.

Review of the resident's April 2012 Medication Administration Record revealed the resident had received 650 milligrams of Tylenol 9 times since he/she saw the dentist on 4/3/12 for tooth pain and also received 220 milligrams Aleve on 4/6/12 at 8:00 A.M. for tooth pain.

During interview with the resident on 4/30/12 at 8:15 A.M. the resident stated he/she had seen the dentist for tooth pain a couple of weeks ago, and needed his/her upper teeth extracted. The resident stated he/she continued to have some teeth and gum discomfort, received Tylenol for the pain and the Tylenol relieved the pain. The resident stated the facility had not informed

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him/her as to when he/she would see the oral surgeon.

During interview with direct care staff J on 4/30/12 at 4:40 P.M. the staff stated the resident had complained of tooth pain a couple of weeks ago, the resident was seen by the dentist and he/she did not know if the resident continued to complain of tooth pain.

During interview with social service staff D on 5/1/12 at approximately 11:15 A.M. the staff reported the resident saw the dentist on 4/3/12, after the dentist recommended the resident see an oral surgeon, and he/she contacted Social and Rehabilitation Services regarding payment for the oral surgeon payment shortly after the 4/3/12 dentist visit. Social Service staff D stated he/she contacted the oral surgeon office around 2 weeks ago tomorrow (on/or around 4/18/12), and the oral surgeon's office faxed the paperwork the Friday of the same week (4/20/12), he/she gave the paperwork to the nursing staff to complete.

Social Service staff D stated once the paperwork was completed, and the facility will forward the paperwork to the resident's guardian for consent. Social service staff D stated after receiving the paperwork back from the resident's guardian the facility would schedule the appointment with the resident's guardian.

During interview with administrative nursing staff C on 5/1/12 at 11:40 P.M. the staff stated the nursing department had not completed the paperwork from the oral surgeon's office. Administrative nursing staff C stated the facility received the forms on 4/24/12. Review of the

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| F 412 | Continued From page 32<br>forms at that time revealed the forms contained demographic and a brief health history review. The review also revealed a facsimile date of 4/24/12 timed 7:27 A.M.<br><br>During interview with administrative nursing staff C on 5/2/12 at approximately 1:15 P.M. the staff stated the facility had not completed the paperwork and did not know when the paperwork would be completed.<br><br>The facility failed to set up an evaluation with an oral surgeon in a timely manner for this resident that complained of tooth and/or gum discomfort. | F 412 | | |
| F 428 SS=E | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 59 residents. The sample included 15 residents. Based on observation, record review and staff interview, the facility failed to identify and monitor targeted behaviors of psychotropic medications for seven of the ten residents reviewed for unnecessary medications (#31, #46, #43, #25, #20, #27, #19). | F 428 | | |

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Findings included:

- Resident #19 had diagnoses that included paranoid schizophrenia, plantar wart, epilepsy and recurrent seizures, constipation, essential tremor, anxiety disorder, dementia with Lewy bodies, nutritional deficiency, insomnia, sleep disturbance, depressive disorder, hypothyroidism, disturbance of skin sensation, secondary Parkinson's, bipolar disorder, dementia with behavioral disturbance, gastroparesis, Barrett's esophagus, peripheral angiopathy, cardiomegaly, anemia, obsessive compulsive disorder, diabetis mellitus type I, and cataract as listed on the April Physician's Order Sheet (POS) dated 4/11/12. The POS also included the following medications: Lunesta 1 milligram (mg.), a sedative/hypnotic, Cymbalta 60 mg., an anti-depressant, Risperdal 0.25 mg., an anti-psychotic, Geodon 60 mg., an anti-psychotic, and Klonopin 0.5 mg., an anti-anxiety.

The quarterly Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/28/12 recorded a Brief Interview for Mental Status (BIMS) of 9 indicated moderate cognitive impairment and received anti-anxiety, anti-psychotic, and anti-depressant medications.

The Care Area Assessment (CAA) dated 12/14/11 for psychotropic medication usage documented he/she had a long term history of mental illness with the use of psychotropic medications. The pharmacist completed a medication regimen review on a monthly basis with no new recommendations noted. The Advanced Registed Nurse Practitioner (ARNP)

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noted he/she was not a current candidate for dose reduction.

The care plan dated 12/29/11 and last reviewed 3/20/12 recorded a potential for drug related cognitive or behavioral impairment due to psychotropic medication usage. The interventions listed nursing staff monitored fluid intake and noted any decreased intake to the charge nurse, nursing staff reported behavioral changes or changes in sleeping pattern to the charge nurse, nursing staff reported changes in Activities of Daily Living (ADL) function to the charge nurse, the pharmacist reviewed medication regimen on a monthly basis, and staff offered him/her hard sugar candy for dry mouth.

The Behavior Monthly Flow Sheet for April 2012 listed the following behaviors: agitated, angry, anxiety, continuous yelling, hallucinations/paranoia/delusion, skipping meals, and refusing care. This sheet listed the following medications: Lunesta 1 milligram (mg.), a sedative/hypnotic, Cymbalta 60 mg., an anti-depressant, Risperdal 0.25 mg., an anti-psychotic, Geodon 60 mg., an anti-psychotic, and Klonopin 0.5 mg., an anti-anxiety. This sheet did not specify which medications were related to which behaviors.

An observation on 5/1/12 at 8:00 A.M. revealed resident consumed breakfast at dining room table, stood up from the table, picked napkin off the floor, then ambulated towards his/her room.

The drug regimen review dated 4/6/12, 3/2/12, 2/8/12, 1/9/12, and 12/2/11 did not address these medication irregularities.

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| F 428 | Continued From page 35<br><br>An interview on 5/1/12 at 11:45 A.M. with licensed nursing staff F indicated that the diagnoses were listed beside the prescribed medications and the targeted behaviors corresponded to the appropriate diagnoses.<br><br>An interview on 5/1/12 at 1:15 P.M. with administrative nursing staff C was unable to provide information on residents' targeted behaviors related to diagnosis and medications.<br><br>An interview on 5/2/12 at 12:50 P.M. with pharmacist consultant N, stated he/she completed medication monitoring on a monthly basis. He/she monitored medication orders, recent lab work, and physician progress note. He/she stated specific medications did not have specific targeted behaviors as all the medication regimen controlled all of the behaviors. He/she addressed the issue with the facility for targeted behaviors to correspond with specific medications.<br><br>An interview on 5/2/12 at 3:30 P.M. with administrative staff A reported the facility contacted consulting pharmacist N on 5/2/12, and reported he/she did not make any recommendations on behavior monitoring forms.<br><br>Review of the facility policy/procedure for Behavior Management Guideline revised January 2011, recorded "prior to the initiation of antipsychotic medication a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use.".<br><br>The Consultant N failed to identify medication | F 428 | | |

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irregularities and failed to report to the physician and the facility.

- Resident #31 had diagnoses that included paranoid schizophrenia, hyperlipidemia, insomnia due to mental disorder, allergic rhinitis, depressive disorder, esophageal reflux, traumatic amputation of arm and hand unilateral below elbow, anxiety, constipation, blindness of both eyes , and agoraphobia with panic disorder as listed on the April 2012 Physician's Order Sheet (POS). The POS included the following medications: Trazodone 250 milligrams (mg.), an anti-depressant, Clozaril 250 mg., an anti-psychotic, Celexa 20 mg., an anti-depressant, and Klonopin 1 mg., an anti-anxiety.

The quarterly Minimum Data Set (MDS)3.0 with an Assessment Reference Date (ARD) of 1/27/12 recorded a Brief Interview of Mental Status (BIMS) of 15 which indicated the resident was cognitively intact and received anti-psychotic, anti-anxiety, and anti-depressant medications.

The Care Area Assessment (CAA) dated 8/25/11 triggered for psychotropic drug use.

The care plan dated 9/30/11 and last reviewed 2/16/12 listed psychotropic medication monitoring for side effects and targeted behaviors included: Trazadone, Clozaril, Celexa, and Klonopin.

The Behavior Monthly Flow Sheet for April 2012 listed the following behaviors: anxiety, continuous yelling, and hyperventilating. The sheet listed the following medications: Trazadone 250 mg., an anti-depressant, Clozaril 250 mg., an

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anti-psychotic, Celexa 20 mg., and Klonopin 1 mg. This sheet did not specify which medications were related to which behaviors.

An observation on 4/30/12 at 10:20 A.M. resident observed near the entrance door entering from the smoking area, resident held a cane and requested staff to assist him/her to room, staff escorted resident to his/her room, resident did not use walking cane during ambulation.

The drug regimen review dated 4/4/12, 3/2/12, 2/2/12, 1/4/12, and 12/2/11 did not address these medication irregularities.

An interview on 5/1/12 at 11:45 A.M. with licensed nursing staff F indicated that the diagnoses were listed beside the prescribed medications and the targeted behaviors corresponded to the appropriate diagnoses.

An interview on 5/1/12 at 1:15 P.M. with administrative nursing staff C was unable to provide information on residents' targeted behaviors related to diagnosis and medications.

An interview on 5/2/12 at 12:50 P.M. with pharmacist consultant N stated he/she completed medication monitoring on a monthly basis. He/she monitored medication orders, recent lab work, and physician progress note. He/she stated specific medications did not have specific targeted behaviors as all the medication regimen was controlled all of the behaviors. He/she addressed the issue with the facility for targeted behaviors to correspond with specific medications.

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An interview on 5/2/12 at 3:30 P.M. with administrative staff A reported the facility had contacted consulting pharmacist N on 5/2/12, and reported he/she did not make any recommendations on behavior monitoring forms.

Review of the facility policy/procedure for Behavior Management Guideline revised January 2011, recorded "prior to the initiation of antipsychotic medication a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use."

The Consultant N failed to identify medication irregularities and failed to report to the physician and the facility.

- Resident # 43 had diagnoses that included schizoaffective disorder, skin and subcutaneous tissue infections, allergic rhinitis, hypertension, post-traumatic stress disorder, borderline personality disorder, esophageal reflux, diabetes mellitus type II, urinary incontinence, rosacea, varicose veins of lower extremities, polycystic ovaries, obesity, Hirsutism,coronary atheroslerosis, tobacco use, hyperlipididemia, myalgia and myositis, osteoartherosis, anemia, fibroadenosis of breast, sensoneural hearing loss, lumbago, external thrombosed hemorrhoids, symptomatic menopausal/female climacteric states, psychosis, reactive confusion, pain in joints of pelvic region and thigh, bursitis, osteoporosis, constipation, hypothyroididism, migraine, extrapyramidal movement disorder, hypertension, and insomnia as listed on the April Physician's Order Sheet (POS) dated 4/20/12. The POS included the following medications:

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Zyprexa 10 milligrams (mg.), an anti-psychotic, Ativan 1 mg., an anti-anxiety, and Paxil 10 mg., an anti-depressant.

The quarterly Minimum Data Assessment (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/17/12 recorded a Brief Interview of Mental Status (BIMS) of 15 which indicated the resident was cognitively intact, and received anti-psychotic and anti-depressant medications.

The Care Area Assessment (CAA) dated 12/6/11 triggered for psychotropic medication usage.

The care plan dated 9/30/11 and last reviewed 2/16/12 listed psychotropic medication monitoring for side effects and targeted behaviors included: Ativan, Paxil and Zyprexa.

The Behavior Monthly Flow Sheet for April 2012 listed the following behaviors: anxiety, continuous screaming/yelling, hallucinations/paranoia/delusions, isolation, hoarding, damaging property, and giving away items and then accusing others of stealing. This sheet listed the following medications: Zyprexa 10 mg., an anti-psychotic, Ativan 1 mg., an anti-anxiety, and Paxil 10 mg., an anti-depressant.

An observation on 4/30/12 at 12:30 P.M. revealed the resident sat at the dining room table in a straight back chair

The drug regimen review dated 4/4/12, 3/2/12, 2/2/12, 1/4/12, and 12/2/11 did not address these medication irregularities.

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An interview on 5/1/12 at 11:45 A.M. with licensed nursing staff F indicated that the diagnoses were listed beside the prescribed medications and the targeted behaviors corresponded to the appropriate diagnoses.

An interview on 5/1/12 at 1:15 P.M. with administrative nursing staff C was unable to provide information on residents' targeted behaviors related to diagnosis and medications.

An interview on 5/2/12 at 12:50 P.M. with pharmacist consultant N stated he/she completed medication monitoring was completed on a monthly basis. He/she monitored medication orders, recent lab work, and recent physician progress note. He/she stated specific medications did not have specific targeted behaviors as all the medication regime controlled all of the behaviors. He/she addressed the issue with the facility for targeted behaviors to correspond with specific medications.

An interview on 5/2/12 at 3:30 P.M. with administrative staff A reported the facility contacted the consulting pharmacist N on 5/2/12, and reported he/she had not made any recommendations on behavior monitoring forms.

Review of the facility policy/procedure for Behavior Management Guideline revised January 2011, recorded "prior to the initiation of antipsychotic medication a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use."

The Consultant N failed to identify medication irregularities and report to the physician and the

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facility.

- Resident #46 had diagnosis that included schizophrenia, edema, hypothyroidism, depressive disorder, hyperlipidemia, adjustment disorder with anxiety, psychosis, mood disorder, personal history of traumatic brain injury, diabetes mellitus type II, and atopic dermatitis as listed on the April Physician's Order Sheet (POS) dated 4/25/12. The POS included the following medications: Paxil 20 milligrams (mg.), an anti-depressant, Haloperidol 5 mg., an anti-psychotic, Seroquel 300 mg., an anti-psychotic, Lorazepam 2 mg., an anti-anxiety, and Hydroxyzine 25 mg., an anti-anxiety.

The significant change Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/7/12 recorded a Brief Interview for Mental Status (BIMS) of 6 which indicated the resident was severely impaired cognitively and received anti-psychotic, anti-anxiety, and anti-depressant medications.

The Care Area Assessment (CAA) dated 2/7/12 triggered for psychotropic drug usage.

The care plan dated 12/26/11 recorded potential for drug related complications associated with use of psychotropic medications related to anti-anxiety, anti-depressant, and anti-psychotic medications.

The Behavior Monthly Flow Sheet for April 2012, listed the following behaviors: agitated, compulsive, false beliefs, striking out/hitting, intrusive, inappropriate physical/sexual behavior,

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and trespassing. This sheet listed the following medications: Paxil 20 milligrams (mg.), an anti-depressant, Haloperidol 5 mg., an anti-psychotic, Seroquel 300 mg., an anti-psychotic, Lorazepam 2 mg., an anti-anxiety, and Hydroxyzine 25 mg., an anti-anxiety. This sheet did not specify which medications were related to which behaviors.

An observation on 4/30/12 at 12:10 P.M. resident sat in a wheelchair at the dining room table eating lunch.

The drug regimen review dated 4/4/12, 3/2/12, 2/2/12, 1/4/12, and 12/2/11 did not address these medication irregularities.

An interview on 5/1/12 at 11:45 A.M. with licensed nursing staff F indicated that the facility listed the diagnoses beside the prescribed medications and the targeted behaviors corresponded to the appropriate diagnoses.

An interview on 5/1/12 at 1:15 P.M. with administrative nursing staff C was unable to provide information on residents' targeted behaviors related to diagnosis and medications.

An interview on 5/2/12 at 12:50 P.M. with pharmacist consultant N he/she stated he/she completed medication monitoring on a monthly basis. He/she monitored medication orders, recent lab work, and recent physician progress note. He/she stated specific medications did not have specific targeted behaviors as all the medication regime controlled all of the behaviors. He/she addressed the issue with the facility for targeted behaviors to correspond with specific

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medications.

An interview on 5/2/12 at 3:30 P.M. with administrative staff A reported the facility contacted the consulting pharmacist N on 5/2/12, and reported he/she had not made any recommendations on behavior monitoring forms.

Review of the facility policy/procedure for Behavior Management Guideline revised January 2011, recorded "prior to the initiation of antipsychotic medication a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use."

The Consultant N failed to identify medication irregularities and report to the physician and the facility.

- Review of resident #25's 4/25/12 Physician Order Sheet dated 4/25/12 identified the resident had diagnoses that included: Schizophrenia, extrapyramidal abnormal movement disorder, hypothyroidism, rash, hypopatassemia, edema, anxiety, lipoid metabolism, paranoid personality disorder, peripheral vascular disease, esophageal reflux disease, obesity, depression, osteoarthrosis involving multiple sites, hypertension, and convulsions.

The resident's annual Minimum Data Set 3.0 with an assessment reference date of 12/29/11 identified the resident had short and long term memory problems, hallucinations, delusions, and did not receive antipsychotics, antianxiety medication or antidepressants.

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The resident's care plan dated 4/23/12 included the resident received the following medications Zyprexa (an antipsychotics), Haldol (an antipsychotics), Ativan (an anti-anxiety), and Klonpin (an anti-anxiety). The care plan included the facility monitored the resident for side effects related to his/her medications and also monitored the resident's behavior.

The resident's March and April 2012 behavior monthly flow sheet identified the facility monitored the resident for the following behaviors: Agitation, continuous pacing, hallucinations/paranoia/delusions, demanding tea, refusing medications, refusing hygiene and showers, and continuous physical aggression and failed to show the relationship of drug class/names against specific targeted behaviors. The resident's behavior monthly flow sheets for April and March 2012 listed the following medications: Haloperidol (an antipsychotics), Ativan (an anti-anxiety), and Klonopin (an anti-anxiety).

The drug regimen review for 6/01/11-4/06/12 lacked evidence the pharmacist had identified and communicated to the facility staff the issue regarding targaret behaviors.

An interview on 5/01/12 at 11:45 A.M. with licensed nurse F about behavior sheets, the staff indicated that the facility listed the diagnoses beside the prescribed medications. The staff could not correlate the resident ' s targeted behaviors to the medications.

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An interview on 5/01/12 at 4:00 P.M., with the licensed staff H regarding targeted behaviors, and medications. The nurse was unable to relate the correlation of the targeted behaviors to the appropriate medications.

An interview on 5/01/12 at 1:15 P.M. with the administrative nurse C about targeted behaviors, monitoring, and medications, the staff failed to provide information on resident targeted behaviors related to the medications. The staff failed to provide monitoring of targeted behaviors related to the medications.

An interview on 5/2/12 at 12:50 P.M. with consulting pharmacist N indicated that he/she monitored on a monthly basis the medications, new orders, the medication rooms, and laboratory work. The consulting pharmacist N stated that he/she reviewed new psychotropic orders, new progress notes, reported side effects, and made resident observation to determine if residents' had decompensated. The consulting pharmacist N reported that he/she brought the targareted behavior issue to the attention of the facility and had a discussion with the staff about it. The consulting pharmacist N stated that in the mental health facility he/she considered all medications to be controlling all of the resident's behaviors, and that the physician would have to address the issue.

During an interview on 5/2/12 at 3:30 P.M. with administrative staff A the staff stated thefacility contacted the consulting pharmacist N on 5/2/12, and the consulting pharmacist reported that he/she had not made any recommendations on the behavior monitoring forms.

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The facility policy dated January 2011 indicated, " Prior to the initiation of an antipsychotics medication a physician ' s order is obtained to include the diagnoses and targeted behavior that warrant the medication use. "

The facility failed to identify which behaviors related to which psychotropic medications on the behavior monitoring sheet for the monitoring of efficacy.

- Review of resident #27's Physician Order Sheet dated 4/11/12 identified the resident had diagnoses that included: Paranoid schizophrenia, edema, anxiety, iron deficiency, anemia, constipation, nutritional deficiency, diabetes Type 1, allergic rhinitis, asthma, dementia with lewy bodies, neurogenic bladder, depressive disorder, embolism and thrombosis of artery, hypothyroidism, and hyperlipidemia.

The resident's Significant change Minimum Data Set with an asessment reference date of 7/11/11 identified the resident scored 10 (moderately cognitively impaired) on the Brief Interview for Mental Status, had hallucinations, delusions, and received antipsychotics and antidepressant medications.

The resident's care plan dated 3/22/12 included the resident received Celexa (an antidepressant), Klonpin (an anti-anxiety), Clozaril (an antipsychotics), Geodon (an antipsychotics), Abilify (an antipsychotics) and Seroquel (an antipsychotics). The care plan included the facility monitored the resident for side effects related to the medications and also monitored the

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resident's behavior.

The resident's March and April 2012 behavior monthly flow sheet identified the facility monitored the resident for the following behaviors: Agitation,crying,yelling,hallucinations/paranoia/delusion and intrusiveness and failed to show the relationship of drug class/names against specific targeted behaviors. The March and April 2012 behavior monthly flow sheet listed the resident received the following medications: Ability, Geodon, Celexa, Seroquel, Clozaril and Klonopin.

The drug regimen review for 6/01/11-4/06/12 lacked evidence the pharmacist had identified and communicated to the facility staff the issue regarding targaret behaviors.

An interview on 5/01/12 at 11:45 A.M. with licensed nurse F about behavior sheets, the staff indicated that the facility listed the diagnoses beside the prescribed medications. The staff could not correlate the resident ' s targeted behaviors to the medications.

An interview on 5/01/12 at 4:00 P.M., with the licensed staff H regarding targeted behaviors, and medications. The nurse was unable to relate the correlation of the targeted behaviors to the appropriate medications.

An interview on 5/01/12 at 1:15 P.M. with the administrative nurse C about targeted behaviors, monitoring, and medications, the staff failed to provide information on resident targeted behaviors related to the medications. The staff failed to provide monitoring of targeted behaviors related to the medications.

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An interview on 5/2/12 at 12:50 P.M. with consulting pharmacist N indicated that he/she monitored on a monthly basis the medications, new orders, the medication rooms, and laboratory work. The consulting pharmacist N stated that he/she reviewed new psychotropic orders, new progress notes, reported side effects, and made resident observation to determine if residents' had decompensated. The consulting pharmacist N reported that he/she brought the targareted behavior issue to the attention of the facility and had a discussion with the staff about it. The consulting pharmacist N stated that in the mental health facility he/she considered all medications to be controlling all of the resident's behaviors, and that the physician would have to address the issue.

During an interview on 5/2/12 at 3:30 P.M. with administrative staff A the staff stated thefacility contacted the consulting pharmacist N on 5/2/12, and the consulting pharmacist reported that he/she had not made any recommendations on the behavior monitoring forms.

The facility policy dated January 2011 indicated, " Prior to the initiation of an antipsychotics medication a physician ' s order is obtained to include the diagnoses and targeted behavior that warrant the medication use. "

The facility failed to identify which behaviors related to which psychotropic medications on the behavior monitoring sheet for the monitoring of efficacy.

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- Resident #20 had a diagnoses 3/03/12 Schizoaffective disorder chronic, hypertension, onychia and paronychia of toe, anxiety disorder conditions classified elsewhere, generalized pain, insomnia due to mental disorder, unspecified, extrapyramidal diagnoses and abnormal movement disorder, unspecified constipation, and unspecified hypothyroidism.

The annual Minimum Data Set dated 04/11/12 recorded the resident had a brief interview for mental status score of 15 (cognitively intact), schizoaffective disorder with delusions and hallucinations, anxiety with insomnia, had a mood score of 0, required setup assistance with bathing and supervision at meals, preferences for routine and activities was very important, and received an antipsychotic, antianxiety, and hypnotic medication.

The Care Area Assessment (CAA) dated 4/11/12 for psychotropic medications recorded the resident received Seroquel and Invega for schizoaffective disorder, the antianxiety medication Lorazepam when necessary, and the hypnotic medication Ambien for insomnia. The CAA showed the resident had delusional thinking with paranoia of others, especially where his/her belongings were concerned and became anxious thinking others stole his/her property. The resident used these medication due to long term history of mental illness with the use of high risk medications.

The care plan dated 4/11/12 reported the potential for drug related complications associated with the use of psychotropic medications and for the staff to monitor for side

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effects and report to the doctor any antidepressant sedation, and decreased self-esteem. Interventions included for the staff to assess for pain, monitor for side effects and report to doctor any antipsychotic medication side effects such as sedation, drowsiness, dry mouth, constipation, blurred vision, extra pyramidal syndrome (EPS), weight gain, and edema,

The care plan dated 4/26/12 for potential for drug related complications associated with use of psychotropic medications related to: antianxiety and antipsychotic medications (Ativan, Lorazepam, Seroquel, Invega) docuemented: the resident had a diagnoses of Extra Pyramital Symptoms and was at risk for constipation, for the staff to monitor if the resident had a bowel movement at least every 3 days, and to be free of psychotropic related complications.

Review of February 2012, March 2012, and April 2012 behavior sheets reflected that in February 2012 the resident had 6 of 28 days of pacing/restless behaviors, in March 2012 the resident had 11 of 30 days of pacing/restless continuous behaviors, in April 2012 the resident had 18 of 30 days of pacing, restless behaviors between shifts. The behavior monitoring forms listed behavior codes for " continuous pacing, restlessness and elopement risk, "and failed to show the relationship of drug class/names against specific targeted behaviors. The behavior sheets listed Seroquel 400 milligrams (mg), Invega 3mg, and Invega Sustenna intramuscular 156 mg for schizoaffective disorder, lorazepam 2mg for anxiety, and ambien 15mg for insomnia.

Monthly drug regimen review dated

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6/01/11-4/06/12 did not address behavior monitoring for the psychotropic medications.

An observation on 5/01/12 at 8:10 A.M. the licensed nursing staff F identified the resident, and administered the resident the 8:00 A.M. medications. The resident took the medication, then went and sat down in the brown recliner in the day hall.

An observation 5/01/12 at 4:45 P.M., the licensed nurse G gave the resident his/her 5:00 P.M. medications which consisted of Seroquel and Propranolol when the resident was up at the medication cart.

An interview on 5/01/12 at 11:45 A.M. with licensed nurse F about behavior sheets, the staff indicated that the facility listed the diagnoses beside the prescribed medications. The staff could not correlate the resident's targeted behaviors to the medications.

An interview on 5/01/12 at 4:00 P.M., with the licensed staff H regarding targeted behaviors, and medications. The nurse was unable to relate the correlation of the targeted behaviors to the appropriate medications.

An interview on 5/01/12 at 1:15 P.M. with the administrative nurse C about targeted behaviors, monitoring, and medications, the staff failed to provide information on resident targeted behaviors related to the medications. The staff failed to provide monitoring of targeted behaviors related to the medications.

An interview on 5/02/12 at 12:50 P.M. with

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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consulting pharmacist N indicated that they monitored on a monthly basis the medications, new orders, the medication rooms, and laboratory work. The consulting pharmacist N stated that they reviewed new psychotropic orders, new progress notes, reported side effects, and made resident observation to determine if residents had decompensated. The consulting pharmacist N reported that the targeted behavior issue he/she had brought the issue to the attention of the facility and had a discussion with the staff about it. The consulting pharmacist N stated that in the mental facility they considered all medications to be controlling all of the resident's behaviors, and that the physician would have to address the issue.

The facility policy dated January 2011 indicated, "Prior to the initiation of an antipsychotic medication use, a physician order is obtained to include the diagnosis and targeted behaviors that warrant the medication use."

An interview on 5/02/12 at 3:30 P.M. the administrative staff A stated the facility contacted the consulting pharmacist N on 5/02/12, and reported that he/she had not made any recommendations on the behavior monitoring forms.

The facility pharmacy consultant N failed to identify medication irregularities to the physician and facility.